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TACKLING ALCOHOL MISUSE

Needs in adolescents



JONATHAN HODDLE/REX

Parker et al's review of alcohol misuse did not deal with the problems and needs of adolescent drinkers, who often present to emergency departments when drunk.¹ Alcohol misuse is common in this age group and its incidence is rising, at great cost to individuals, families, and wider society. It is significantly associated with risk of suicide, violence, and accidents—the most common causes of death for young people.² It is also an important marker of serious social problems, which should be explored with all those who present to health services.³

Despite this, emergency department doctors often don't screen for alcohol misuse in young people and are poor at recognising it without formalised screening tools. AUDIT and its derivatives can be used in adolescents, although lower cut-off scores than for adults are probably wise. Just asking, "How often do you get drunk?" identifies young people at risk of traumatic injury through drinking,⁴ and the Paddington alcohol test identifies "binge" drinkers.⁵

Testing blood alcohol levels at presentation is no substitute for formally investigating drinking habits and risk behaviour because young people are drunk at lower blood alcohol concentrations than adults and binge drinking is intermittent. Although it has been reported that young people are more prone than adults to hypoglycaemia when drunk, this is rare. Other pathologies must be considered in intoxicated adolescents with hypoglycaemia, including infection or additional toxic and metabolic insults.

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Typical British malaise

It is depressing that even when the *BMJ* recruits an opinion on the UK's alcohol problems from outside the UK,¹ the barren response is the same as for so many of our pressing national issues—ban it, exclude it, repair it, or tax it to the level of inaccessibility. Why are we ever more incapable of looking at the roots of a problem—whether it is social violence, failing education, *Clostridium difficile* infections on wards—and trying to remedy them. Weren't we always taught at medical school that prevention is better than cure?

We are supposed to be part of a European community, within which alcohol taxes are generally low because most citizens have a responsible approach to alcohol. A few Nordic countries, Britain, and Ireland are exceptions. Our culture of "let's go out and get pissed"—widely admired here, even if secretly—is alien to people in mainland Europe.

What is the problem in attacking that culture and changing it if we believe that the problems of alcohol merit it, perhaps with a sustained campaign in schools? Why shouldn't we levy an immediate £100 fine for public drunkenness if blood alcohol concentrations are over, say, 250 mg/100 ml? If there was the will to send out strong messages, then attitudes could be changed rapidly. Moreover, this government is not shy of social engineering, so is it simply laziness that stops it dealing with the roots of this problem? The possibility of vested interests is a matter for further speculation.

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DIABETES EDUCATION

Selection bias in cluster trial

The large cluster randomised controlled trial by Davies et al suffers from recruitment bias as a result of poor allocation concealment,¹ which is crucial in both individually randomised trials and cluster trials. Allocation was not concealed from the people doing the recruiting, so there is a danger of recruitment bias. Indeed, the nature of the intervention—an educational package—would be likely to increase recruitment bias—a form of selection bias. This possibly occurred in this trial as more of the intervention practices recruited participants and they each recruited more participants than the control practices. Even if the numbers had been similar, we could not be sure that participants were similar in unknown characteristics.

This design flaw has been pointed out in the past,² and it can be dealt with by using someone who is blind to the allocation and study hypothesis to recruit participants.³ We can only, at best, treat data from this study as good observational data. A systematic review of cluster trials published in the *BMJ* and other leading medical journals some years ago found that 40% of them had some form of bias because of poor design.³ It seems that this poor design practice is still ongoing in *BMJ* reported cluster trials.

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- 1 Davies MJ, Heller S, Skinner TC, Campbell MJ, Carey ME, Cradock S, et al, on behalf of the Diabetes Education and Self Management for Ongoing and Newly Diagnosed Collaborative. Effectiveness of the diabetes education and self management for ongoing and newly diagnosed (DESMOND) programme for people with newly diagnosed type 2 diabetes: cluster randomised controlled trial. *BMJ* 2008;336:491-5. (1 March.)
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Pilot educational interventions

It is disappointing, though perhaps not surprising, that the intervention and control groups in the DESMOND study showed no difference in glycated haemoglobin or in any quality of life measure at one year.¹ The difference of 1.1 kg in weight—though significant—is not, frankly, terribly impressive.

Many of us were alarmed when the Department of Health began to exert pressure

on diabetes services to adopt and implement DESMOND before a proper evaluation. We now see that this approach is unlikely to be cost effective in the management of most patients with type 2 diabetes, and the case for its universal introduction has effectively collapsed.

The lesson here is that—just like drugs or surgical procedures—educational interventions need rigorous piloting and assessment, as was performed by the DESMOND group, before politicians jump on the bandwagon and insist that they are the answer to everybody's prayers.

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JOINING THE DOTS

National "twin study"

Davies and Squire say it's too soon to conclude on the efficacy of directly observed treatment short courses (DOTS) for treating tuberculosis.¹

Norway and Sweden are sociodemographically, politically, and culturally comparable. However, the Norwegian tuberculosis control programme fully complies with the DOTS strategy promoted by the World Health Organization and the International Union Against Tuberculosis and Lung Diseases, but that in Sweden does not. Most strategies for preventing tuberculosis in the two countries are otherwise comparable to the US and most European countries, so these "twin countries" provide an excellent "case-control model" to study the effect of DOTS nationally.

Transmission of tuberculosis is stable in Norway, despite its import from immigration and increasing incidence.² Immigrants from regions with high rates of tuberculosis bring in different strains of *Mycobacterium tuberculosis*, but they do not significantly contribute to the spread of disease in the resident population.

Serious shortcomings have been revealed in Sweden, however.³ The National Board of Health and Welfare has criticised the Swedish

Institute for Infectious Disease Control for not stopping the spread of drug resistant *M tuberculosis* in Stockholm.^{3 4}

The epidemiology of tuberculosis is completely different in the two countries. By introducing obligatory DOTS to all patients, Norwegian health personnel accomplish prompt diagnosis and treatment in a diverse population.^{2 5} In Sweden, however, control is complicated by the lack of DOTS.³ This situation is a strong argument for introducing DOTS in all countries where it has not yet been implemented.

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Competing interests: None declared.

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PRIVATE COMPANIES AND GPS

A crucial juncture

The NHS is at a crucial juncture, as Salisbury points out.¹ At issue is whether the British public is better served by owner operated independent small GP businesses or by corporate practices, in which the autonomy of GPs is reduced. Corporatisation could result in practices being privately funded and designed, with the doctor retaining autonomy and responsibility for "business" or it could move towards doctors being hired hands.

My first hand experience of corporate practices in the US may be useful. First the good news. Such practices bring capital and standardised organisational procedures and supports to bear. I never had to worry about billings (I was mostly salaried), equipment, upkeep, or even about coverage arrangements, which were largely worked out by the administration. From the patient perspective, the health centres and procedures were standardised and predictable. And the quality of care was largely "baked in," part of my belonging to a large group of GPs who shared night coverage and oversaw each others' work.

Now the bad news. Over time, most GPs who work in such settings risk losing some of the personal challenge and the thrill (and despair) of being at financial risk for their work. Orientation shifts from being an owner to an employee.

As an owner, you know that the quality of your work and availability is a crucial determinant of

whether your practice thrives. You work harder because the market gives your patients choice about whether they stay with you. In corporate general practices, especially when salaried, doctors are more removed from whether their patients come back to them. Inevitably, for some but not all GPs, salary comes to seem owed to them and they turn to managing the time or effort required by the work rules.

Just how important is the independent ownership of general practice? That question must be argued. Ultimately, the public will make the decision in a market driven, purchaser-provider split. But by the time the market's position is clear, much could be lost and the outcome could be irreversible. Now is the time to get this discussion out in the open.

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- 1 Salisbury C. The involvement of private companies in NHS general practice. *BMJ* 2008;336:400-1. (23 February.)

An inconvenient truth

Salisbury repeats the commonly quoted argument that "private provision can create conflicts for doctors between what is best for patients and best for profits, and this can undermine trust between patients and doctors."¹

The editorial implies that this conflict is unique to doctors working for private providers. It is an incredible achievement that—60 years since general practices first contracted to provide services for the NHS—the profession has convinced the public, and sometimes even itself, that there is no profit motive involved in the way traditional partnerships run their surgeries. There is.

As a rule, every pound spent on nursing staff, medical equipment, or premises is one less pound of profit for a partnership. It could be argued that a salaried GP working for a private provider has less conflict of interest than a GP partner—the salaried GP is unlikely to receive much, if any, of the savings made from day to day decisions, while a partnership will receive 100% of any savings in practice expenditure.

We need to acknowledge both the weaknesses and the strengths of the independent contractor system. It is our honesty and openness as a profession that has built up the trust that is now at stake. Ignoring inconvenient truths will not help our cause in the long run.

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